

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4965 CERTIFICATE OF DEATH

0405166
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 3Mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jennie Louise Allen				4. DATE OF DEATH Month Day Year April 28 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1861	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McCormick				14. MOTHER'S MAIDEN NAME Jane Rowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James Allen Address Pittsburgh, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Heart Disease DUE TO (c) Senility							INTERVAL BETWEEN ONSET AND DEATH 1-Hours Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 12-5-55 to April 28, 1956 that I last saw the deceased alive on April 28, 1956 , and that death occurred at P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Feaster, Jr.				ADDRESS (Street, city or town, state) 58 2nd St. Oakland, Md. DATE SIGNED 5-2-56			
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 4/30/56 REGISTRAR'S SIGNATURE Julius Rowan	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

166

BUREAU V. 2

MAY 7 1956

RECEIVED

4/20/56

4066
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First WALTER Middle LEONARD Last BURKHARD		4. DATE OF DEATH Month April Day 14 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1893
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm	
11. BIRTHPLACE (State or foreign country) Accident, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Burkhard		14. MOTHER'S MAIDEN NAME Mary Zinken	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Artie Burkhard, Accident, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute diaphragmatic pleurisy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26, 1955 to April 14, 1956 , that I last saw the deceased alive on April 12, 1956 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Paige Strong M.D.		ADDRESS (Street, city or town, state) Salisbury, Penna DATE SIGNED April 14, 56	
PHYSICIAN'S NAME (Type) A. PAEGE STRONG		SAILABURY, PA.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/56	
22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		22d. LOCATION (City, town, or county) (State) Accident, Garrett Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald F. Newman		ADDRESS Grantsville, Md.	
24a. REC'D BY REGISTRAR APR 18 1956		24b. REGISTRAR'S SIGNATURE D. H. Hedrick	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

BUREAU V. 3

APR 18 1956

RECEIVED

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/95

166

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
1956

Handwritten signature

BUREAU V. S.

MAY 1 1956

RECEIVED

Handwritten notes:
11 to 12/1/56
12/1/56 to 12/1/56
12/1/56 to 12/1/56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04055

Reg-Data No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville.			c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Eisentrout. Last				4. DATE OF DEATH Month 4-19-56. Day 19 Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 7th, 1887.	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner.	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Perkin, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles H. Eisentrout.				14. MOTHER'S MAIDEN NAME Annie Jones.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 214-01-9750		17. INFORMANT E. Eisentrout	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure. DUE TO Alcoholism Conditions, if any, which gave rise to immediate cause (b) Alcoholism (c), stating the underlying cause lost, DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE E. Irving Baumgartner				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) E. Irving Baumgartner, M.D.				DATE SIGNED April 21, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-21-56.		22c. NAME OF CEMETERY OR CREMATORY Addison Cemetery,		22d. LOCATION (City, town, or county) (State) ADDISON, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE H. B. Risherberger				24a. REC'D BY REGISTRAR 4/21/56			
ADDRESS ADDISON, PA.				24b. REGISTRAR'S SIGNATURE Max Ruth Frantz			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
PUBLIC HEALTH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

RECEIVED
MAY 9 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4069 CERTIFICATE OF DEATH

04056

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>West Virginia</u> COUNTY <u>Preston</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Oakland</u>		LENGTH OF STAY (in this place) <u>7 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Terra Alta</u>		<u>15 x - 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garrett County Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Route # 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DONNA</u> (Middle) <u>SUE</u> (Last) <u>FORD</u>				(Month) <u>April</u> (Day) <u>3</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>July 19, 1955</u>	9. AGE last birthday --- yrs. <u>8</u>	IF UNDER 1 YEAR Months <u>14</u>	IF UNDER 24 HRS. Hours <u>14</u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Terra Alta, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Robert Lemar Ford</u>				14. MOTHER'S MAIDEN NAME <u>Dottie Sue Metheny</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Robert Lemar Ford</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>480x</u> IMMEDIATE CAUSE (A) <u>Lobar Pneumonia</u>				<u>Influenza</u>		<u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Influenza</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Influenza</u>							
19. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 31, 1956</u> , to <u>Apr 3, 1956</u> , that I last saw the deceased alive on <u>Apr 3, 1956</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Chas. E. Smith</u> M.D.				ADDRESS (Street, city, town, state) <u>Terra Alta, West Virginia</u>		DATE SIGNED <u>4/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal & Burial</u>		DATE THEREOF <u>April 6, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		LOCATION (City, town, or county) (State) <u>Terra Alta, West Virginia</u>	
24. REC'D BY REGISTRAR <u>4/5/56</u>		REGISTRAR'S SIGNATURE <u>Julie H. Rowland</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. K. WATSON</u> <u>Terra Alta, W. Va.</u>			

156

APR 24 1956

RECEIVED

4/2/25
J. C. H. H. H. H.

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4070 CERTIFICATE OF DEATH

04057
166

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sang Run</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sang Run</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>---</u>		LENGTH OF STAY (If this place) <u>76 Yrs.</u>		STREET ADDRESS <u>---</u>		(If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Vestus C. Friend</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 18, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 7, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zadock Friend</u>				14. MOTHER'S MAIDEN NAME <u>Alice Friend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT & ADDRESS <u>Wm. Martin Friend Sang Run, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Acute Circulatory Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Vascular Accidents</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertension</u>				<u>7</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Chas</u> <u>1956</u> <u>to</u> <u>Apr 18</u> <u>1956</u> <u>that I last saw the deceased</u> <u>alive on</u> <u>Apr 18</u> <u>1956</u> <u>and that death occurred at</u> <u>7:20 P.M.</u> <u>from the causes and on the date stated above.</u>							
SIGNATURE <u>W. H. Sumner</u> <u>father</u> <u>M.D.</u> <u>Baltimore Md</u>				DATE SIGNED <u>4/20/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/21/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Sang Run Cemetery</u>		LOCATION (City, town, or county) <u>Sang Run, Md.</u>	
24. REC'D BY REGISTRAR <u>4/21/56</u> <u>J. H. C. Rowan</u> <u>SP</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Leighton</u> <u>Oakland, Md.</u>			

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4071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MD b. COUNTY GARRETT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last HELEN LOUISE GIBSON		4. DATE OF DEATH Month Day Year APRIL 15 1956	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-31-1879
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OAKLAND MD	
11 BIRTHPLACE (State or foreign country) U.S.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME EDWARD H. BARTLETT		14. MOTHER'S MAIDEN NAME HARRIETT FAIRALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT WILLIAM GIBSON		Address OAKLAND MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic poisoning DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (a) malnutrition			INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 16 1951 to April 15 1956 , that I last saw the deceased alive on April 14 1956 , and that death occurred at 4 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. I. BAUMGARTNER M.D.		ADDRESS (Street, city or town, state) 23 Eden St Oakland MD	
PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER		DATE SIGNED 4/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL-17-1956	
22c. NAME OF CEMETERY OR CREMATORY, ADDRESS OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR 4/17/56 24b. REGISTRAR'S SIGNATURE J. A. Brown JR	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11 1/2

BUREAU V. S.

APR 22 1950

RECEIVED

4/24/50

4972

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>W.Va.</u> b. COUNTY <u>Marion</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>4 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Weekes Nursing Home</u>		d. STREET ADDRESS <u>717 Pittsburgh Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>W.</u> Last <u>HALL</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/1877</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chester</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Ray Hall</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Sis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Woodrow Hall</u>		Address <u>Fairmont, W.Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 422.1 DUE TO (b) <u>year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Upper Resp. Infection & Scurvy</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1955</u> to <u>3 Apr. 1956</u> , that I last saw the deceased alive on <u>2 Apr. 1956</u> , and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. Lusby</u> M.D.		ADDRESS (Street, city or town, state) <u>77 Oak St. Oakland, W.Va.</u>	
DATE SIGNED <u>3 Apr. 56</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS F. LUSBY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fiskah Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Monongahela Co., W.Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Verbert C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	
24a. REC'D BY REGISTRAR <u>John A. Hough</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Hough</u>	
DATE <u>4/6/56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0406266

4973

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) EMMA First CODDINGTON Middle LAWTON Last				4. DATE OF DEATH April Month 5 Day 1956 Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July-13-1876	
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GORMAN MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS CODDINGTON				14. MOTHER'S MAIDEN NAME CECELIA JAMISON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS KATHLEEN TURNEY Address OAKLAND MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Arteriosclerosis (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 4 years 8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 6, 1946 , to April 5, 1956 , that I last saw the deceased alive on April 5, 1956 , and that death occurred at 5 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland, Md DATE SIGNED April 6, 1956			
PHYSICIAN'S NAME (Type) A. E. Mance, M.D.				Oakland, Maryland, April 6, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF April-9-1956		22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD.				24a. REG. BY REGISTRAR 4/9/56 24b. REGISTRAR'S SIGNATURE Julius Rowan			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1/2

BUREAU V. S.

APR 24 1956

RECEIVED

4/12/56

4974

CERTIFICATE OF DEATH

04063
766

Reg. Dist. No.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARHETT</u>		MARYLAND		STATE <u>WEST VIRGINIA</u> COUNTY <u>PRESTON</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>		LENGTH OF STAY (in this place) <u>15 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TERRA ALTA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WEEKS NURSING HOME</u> <u>7th and Alder Streets</u>				STREET ADDRESS (If rural give location) <u>Route # 1</u>			
3. NAME OF DECEASED (Type or Print) <u>CORA IDELLA LEE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 19, 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JANUARY 18, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TERRA ALTA, WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>JOHN ABRAHAM FRIEND</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET ELIZABETH ALBRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Arch E. Lee, R #1, TERRA ALTA, W.VA.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-7</u> , 19 <u>55</u> , to <u>4-12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-12</u> , 19 <u>56</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Howard G. G. G. G.</u>				DATE SIGNED <u>April 19, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL & BURIAL</u>				24. REC'D BY REGISTRAR DATE <u>4/20/56</u>			
DATE THEREOF <u>April 21, 1956</u>				NAME OF CEMETERY OR CREMATORY <u>Bever Hills Memorial Gardens, Morgantown, W. Va.</u>			
REGISTRAR'S SIGNATURE <u>Julia A. Rowan LR</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>P. R. WALSON</u>			
ADDRESS (Street, city, town, state) <u>5th & Oak Sts., Oakland, Md.</u>				ADDRESS <u>TERRA ALTA, W. VA.</u>			

221

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1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05158

4975

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		LENGTH OF STAY (in this place) <u>2 wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Post Office, Terra Alta, W. Va.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>55 Alder St.</u>				STREET ADDRESS (If rural give location) <u>Rural Route 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ray</u> (Middle) (Last) <u>Lewis</u>				(Month) (Day) (Year) <u>April 30, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 7, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph F. Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Teets</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY NO. <u>215-36-9524</u>		17. INFORMANT & ADDRESS <u>Asa Lewis Oakland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1956</u> to <u>1956</u> and that I last saw the deceased alive on <u>1956</u> and that death occurred at <u>10:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Herbert C. Leighton</u>				DATE SIGNED <u>11/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/3/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Lake Ford Cemetery</u>		LOCATION (City, town, or county) (State) <u>Garrett Co., Md.</u>	
24. RECEIVED BY REGISTRAR <u>5/3/1956</u>		REGISTRAR'S SIGNATURE <u>Julia H. Brown</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

199

2/21/25 J. H. H. H. H. H.

4976

CERTIFICATE OF DEATH

04064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calhoun</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harrett County Memorial Hospital</u>				e. STREET ADDRESS <u>110 Liberty Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Andrew</u> Last <u>Loraditch</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1871</u>	9. AGE (In years last birthday) <u>34</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Stephen Loraditch</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Weible</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>204-14-74707</u>		17. INFORMANT <u>Mrs. Lay H. Loraditch (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial heart disease</u> 430.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. E. Mance</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland Md</u>		DATE SIGNED <u>2 Apr 56</u>	
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 4-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>OAKLAND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u>				ADDRESS <u>OAKLAND MD.</u>		24a. REC'D BY REGISTRAR DATE <u>7/1/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Julia H. Rowan</u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1/2 COTTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

049856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MICHIGAN</u> b. COUNTY <u>WAYNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - OAKLAND</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WAYNE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>35605 PALMER RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LINDA</u> Middle <u>SUE</u> Last <u>MOON</u>				4. DATE OF DEATH Month <u>APR.</u> Day <u>15</u> Year <u>19 56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>11/8/53</u>			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DETROIT Mich</u>			
13. FATHER'S NAME <u>PAUL F. MOON</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA JANE MATHIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PAUL F. MOON 35605 PALMER RD. WAYNE Mich</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORTICAL DEGENERATION OF BRAIN</u> <u>702X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTERNAL HYDROCEPHALUS</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EMACIATION - DEHYDRATION</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. J. Baumgartner</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. BAUMGARTNER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VALLEY</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u>		ADDRESS <u>OAKLAND - MD</u>		24a. REC'D BY REGISTRAR <u>DATE 4/17/56</u>			
24b. REGISTRAR'S SIGNATURE <u>Julia H. Rowan</u>		(State) <u>MD</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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BUREAU V.

APR 1956

RECEIVED

4/17/56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4978

CERTIFICATE OF DEATH

04066 166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 1 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. STREET ADDRESS 4 Mi. N. Swanton			
3. NAME OF DECEASED (Type or print) First Verna Middle Flora Last Otto				4. DATE OF DEATH Month April Day 10, Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1918	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Floor				14. MOTHER'S MAIDEN NAME Ona Varian			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 285-16-2684		17. INFORMANT William H. Otto Address R. D. Swanton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 16 X DUE TO ARTERIAL HYPERTENSION & FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Chronic Bronchitis & Emphysema (c) SID RHEUMATIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH 4 days 6 mos 15 yrs 30 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from NOV 1955 to APR 10 1956 , that I last saw the deceased alive on APR 10 1956 , and that death occurred at 7 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Feaster, Jr.				ADDRESS (Street, city or town, state) 58 2nd St. Oakland, Md.			
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.				DATE SIGNED 4-10-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1956		22c. NAME OF CEMETERY OR CREMATORY North Glade Cemetery		22d. LOCATION (City, town, or county) (State) near Swanton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR 4/12/56	
				24b. REGISTRAR'S SIGNATURE Julia H. Rowan			

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BUREAU V. S.

APR 24 1956

RECEIVED
FBI
APR 24 1956

4/24/56

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4979

CERTIFICATE OF DEATH

04067

Reg. Dist. No. 172

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		STATE MARYLAND		COUNTY GARRETT			
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN RURAL-SWANTON		LENGTH OF STAY (In this place) 65yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural- SWANTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MT.ZION ROAD R.D. #1				STREET ADDRESS (If rural give location) MT.ZION ROAD- RD.#1			
3. NAME OF DECEASED (First) MARY (Middle) CATHERINE (Last) PAUGH				4. DATE OF DEATH (Month) APRIL (Day) 28 (Year) 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH FEB. 2, 1868	9. AGE last birthday 88 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if SEWING)		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) FAYETTE CO., PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN McNaair				14. MOTHER'S MAIDEN NAME SALLY SUMMIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Nora Barnhouse, Kitzmiller, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Acute Myocardial Infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Heart Disease</i>				<i>24-27</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Hypertension & Arteriosclerosis</i>				<i>5 yrs</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 24</i>, 19<i>56</i>, to <i>April 28</i>, 19<i>56</i>, that I last saw the deceased alive on <i>April 24</i>, 19<i>56</i>, and that death occurred at <i>7:45 A.M.</i>, from the causes and on the date stated above.							
SIGNATURE <i>Nora Barnhouse</i>				ADDRESS (Street, city, town, state) <i>Kitzmiller, Md</i>		DATE SIGNED <i>April 30 56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 2/56		NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		LOCATION (City, town, or county) (State) R.D. #1 Swanton, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>W. B. Baruch</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>O. S. Shanklin</i>			
DATE <i>4/30/56</i>				ADDRESS Blaine, W. Va.			

BUREAU V. S.

MAY 2 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4080 CERTIFICATE OF DEATH

04069

Reg. Dist. No. 172

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M.

1. PLACE OF DEATH COUNTY GARRETT MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER HOSPITAL OR INSTITUTION OR STREET ADDRESS CHURCH STREET				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY GARRETT CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER STREET ADDRESS (If rural give location) CHURCH STREET			
3. NAME OF DECEASED (Type or Print) (First) ROY (Middle) CAROL (Last) SOWERS				4. DATE OF DEATH (Month) (Day) (Year) APRIL 28, 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 26, 1891	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work and state of working life, even if past duties) Constable		10b. KIND OF BUSINESS OR INDUSTRY TOWN		11. BIRTHPLACE (State or foreign country) Hambelton, Grant Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EPHRIAM FILLMORE SOWERS				14. MOTHER'S MAIDEN NAME RACHEL ALICE JUNKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes) <input checked="" type="checkbox"/> (No) <input checked="" type="checkbox"/> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-8849		17. INFORMANT & ADDRESS MRS. Lois Mosser, Kitzmiller, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Acute Coronary Thrombosis						2 days	
ANTECEDENT CAUSE(S) DUE TO Coronary Heart Disease						2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Complete Heart Block						2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1954, to Sept 28, 1956, that I last saw the deceased alive on Sept 28, 1956, and that death occurred at 3:45 PM, from the causes and on the date stated above.							
SIGNATURE Rufus Calabrese		M.D. Kitzmiller, Md.		ADDRESS (Street, city, town, state) Blaine, W. Va.		DATE SIGNED April 30-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-1-56		NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		LOCATION (City, town, or county) (State) Elk Garden, Mineral B W Va.	
24. REC'D BY REGISTRAR DATE 4/30/56		REGISTRAR'S SIGNATURE C. W. Parick		25. FUNERAL DIRECTOR'S SIGNATURE O. B. Sealler, Blaine, W. Va.			

BUREAU V. S.

MAY 2 1956

RECEIVED

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Grantsville		c. LENGTH OF STAY IN 1b 4 wks.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLAN EIZEBETH WILEY						4. DATE OF DEATH Month Apr.		Day 26		Year 1956	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1881		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Avilton, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli Arnold						14. MOTHER'S MAIDEN NAME Tena Knept					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Dora Killus, Grantsville, R.D. 1					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pericardial vascular accident 11X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Myocardial infarction										INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 26, 1956 to April 28, 1956 , that I last saw the deceased alive on April 26, 1956 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MEYERSDALE, PA DATE SIGNED MEYERSDALE, PA											
ACTUAL SIGNATURE Donald J. Newman				M.D. MEYERSDALE, PA							
PHYSICIAN'S NAME (Type) MEYERSDALE, PA											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/29/56		22c. NAME OF CEMETERY OR CREMATORY Grantsville		22d. LOCATION (City, town, or county) (State) Grantsville, Garrett Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman						ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR MAY 3 1956		24b. REGISTRAR'S SIGNATURE D. H. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
ISM 9/55

RECEIVED

MAY 3 1956

BUREAU V. 3

4082

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Grant</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bayard</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lonnie</u> Middle <u>Alton</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1 /1884</u>		9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mail Carrier</u>		11. BIRTHPLACE (State or foreign country) <u>IROTAN, OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ELZA Willis</u>				14. MOTHER'S MAIDEN NAME <u>JULIA WILLIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>236-14-6843</u>		17. INFORMANT Address <u>Mrs. Fred Layman, Bayard, W.Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypochondriac Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-renal Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>6 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>MAR 16, 1956</u> , to <u>APR 13, 1956</u> , that I last saw the deceased alive on <u>APR 13, 1956</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland, Md</u>		DATE SIGNED <u>1/4/56</u>	
PHYSICIAN'S NAME (Type) <u>Andrew E. Mance, M. D.</u>				<u>Oakland, Maryland</u>			
22a. BURIAL, CREMATION, REBURY, etc. (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bayard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bayard, Grant Co., W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. H. H. H. H.</u>				ADDRESS <u>Blaine, W. Va.</u>		24a. RECEIVED BY REGISTRAR DATE <u>4/15/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julius H. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

221

U. S. A.



4/22/20

CERTIFICATE OF DEATH

Reg. Dist. No. 04072

4283

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>WILSON</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 18 1869</u>
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Allenville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Mulhollen</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hanna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Harry Renwick, Grantsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 24</u> , 19 <u>56</u> , to <u>April 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Pa.</u> DATE SIGNED <u>April 28, 1956</u>			
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D. <u>Salisbury, Pa.</u>		PHYSICIAN'S NAME (Type) <u>A. PAIGE STRONG</u> <u>SALISBURY, PA.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Phillipsburg</u>	22d. LOCATION (City, town, or county) (State) <u>Phillipsburg, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald G. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Zdenich</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 3 1956

BUREAU V. S.

4784

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing (Rural Route # 1)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Wilt		4. DATE OF DEATH Month Day Year April 9th. 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1886
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY; 11. BIRTHPLACE (State or foreign country) Swanton, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Noah Wilt	
14. MOTHER'S MAIDEN NAME Alice Broadwater		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT Address Chester Green, Lonaconing, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung - Bronchogenic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) R.F.D. # 1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 m.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1955 to 9 April 1956 , that I last saw the deceased alive on 9 April 1956 , and that death occurred at 6:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George Eichhorn		ADDRESS (Street, city or town, state) DATE SIGNED Lonaconing, Maryland 4/10/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 14/12/1956	22c. NAME OF CEMETERY OR CREMATORY Green Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, MD.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR DATE 4-11/56	
ADDRESS Lonaconing, MD.		24b. REGISTRAR'S SIGNATURE Janette M Boal	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT Co. MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #2			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ALBERT WRIGHT				4. DATE OF DEATH Month Day Year APRIL 29 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1870 OCT. 22, 1870	
9. AGE (In years last birthday) 85 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WILSON MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME WILLIAM WRIGHT			
14. MOTHER'S MAIDEN NAME HARRIETT J. HARVEY				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address HALE WRIGHT. SWANTON MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO leucemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) splenohepatitis DUE TO splenohepatitis (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days 8-10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from April 28 1956, to April 29 1956, that I last saw the deceased alive on April 29 1956, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE A.E. Mance				M.D. 101 Third Street, Oakland, Md. May 1, 1956			
PHYSICIAN'S NAME (Type) A.E. Mance, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY-1-1956		22c. NAME OF CEMETERY OR CREMATORY GEORGE'S CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR SWANTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Baldus				ADDRESS OAKLAND MD.		24a. RECEIVED BY REGISTRAR DATE 5/1/56	
24b. REGISTRAR'S SIGNATURE Julia H. Rowan							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

221

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 2

MAY 7 1956

RECEIVED

2/1/26

CERTIFICATE OF DEATH

04076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		d. STREET ADDRESS 00	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CYRUS Middle MILTON Last YOUNKIN		4. DATE OF DEATH Month April Day 18 Year 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 29, 1877
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier, junior		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Grantsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cyrus Younkin		14. MOTHER'S MAIDEN NAME Anna Firl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 216-07-3865A	
17. INFORMANT Mrs Emma Younkin		Address Grantsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X Gangrene right lower leg DUE TO (b) Specter paralysis right leg DUE TO (c) Parkinson's disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral broncho pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 5, 1956 , to April 18, 1956 , that I last saw the deceased alive on April 17, 1956 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE A. Paige Strong M.D. Salisbury, Penn. Apr 19, 1956			
PHYSICIAN'S NAME (Type) A. PAIGE STRONG		SALISBURY, PA.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/56	22c. NAME OF CEMETERY OR CREMATORY Grantsville	22d. LOCATION (City, town, or county) (State) Grantsville, Garrett Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Donald Newman		ADDRESS Grantsville, Md.	
24a. REC'D BY REGISTRAR APR 23 1956		24b. REGISTRAR'S SIGNATURE H. H. Harkins	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

BUREAU V. S.

APR 23 1956

RECEIVED